

CERTIFICATE OF DEATH

Reg. Dist. No.

07818

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bay View		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Bay View NORTH EAST RURAL	
3. NAME OF DECEASED (Type or print) First Ernest Middle B Last Abrams		4. DATE OF DEATH Month July Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer, ret.		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Abrams		14. MOTHER'S MAIDEN NAME Talitha Janney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-12-2741	
17. INFORMANT Miss Audrey M Abrams, Bay View, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20 , 19 59 , to July 17 , 19 59 , that I last saw the deceased alive on July 16 , 19 59 , and that death occurred at 4 a M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 7/17/59	
ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D. M.D.		Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-59	
22c. NAME OF CEMETERY OR CREMATORY Bay View Meth. Cem.		22d. LOCATION (City, town, or county) (State) Bay View Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Davis ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR JUL 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hunt			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7833 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			c. LENGTH OF STAY IN 1b <u>21</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>JOSEPH</u> Last <u>BRENNAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 30 1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS BRENNAN</u>				14. MOTHER'S MAIDEN NAME <u>No INFO.</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>716-05-3560</u>		17. INFORMANT Address <u>JOSEPH N. BRENNAN ELKTON, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found drowned</u>					
20c. TIME OF INJURY Hour <u>4:25</u> p. m. Month, Day, Year <u>July 22, 1959</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Creek</u>		20f. (City or town) (County) (State) <u>Elkton Cecil Maryland</u>	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: <u>Natural causes</u> <input type="checkbox"/> . <u>Accident</u> <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>						DATE SIGNED <u>7/23/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>7/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>			22d. LOCATION (City, town, or county) (State) <u>ELKTON, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>Elkton, Md.</u>									
24a. REG'D BY REGISTRAR DATE <u>JUL 28 '59</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7850

CERTIFICATE OF DEATH

Reg. Dist. No.

07820

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CONOWINGO		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CONOWINGO	
c. LENGTH OF STAY IN Tb 25YRS		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVA Middle JANE Last BROWN		4. DATE OF DEATH Month JULY Day 1 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAVERNKEEPER		10b. KIND OF BUSINESS OR INDUSTRY TAVERN	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM MILLER		14. MOTHER'S MAIDEN NAME CLARA SHENK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-20-8406	
17. INFORMANT CLIFTON BROWN, CONOWINGO, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO (b) Osteoarthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 , 19 58 , to 7/1 , 19 59 , that I last saw the deceased alive on 7/1 , 19 59 , and that death occurred at 30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md DATE SIGNED 7/1/59 ACTUAL SIGNATURE Neil Taylor M.D. PHYSICIAN'S NAME (Type) Neil Taylor			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/4/1959	
22c. NAME OF CEMETERY OR CREMATORY HOPEWELL		22d. LOCATION (City, town, or county) (State) PORT DEPOSIT, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed, Rising Sun, Md		24a. REC'D BY REGISTRAR JUL 6 '59	
24b. REGISTRAR'S SIGNATURE Ernest L. Hannon			

7851

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 935 - 48th Place, N.E.			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle F. Last BROWN				4. DATE OF DEATH Month July Day 31 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> (Sep) <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-28-93	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Elevator		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Brown - Deceased				14. MOTHER'S MAIDEN NAME Mary (?) Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 125-038-743		INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonitis bilateral unresolved 203x DUE TO (b) Plasma cell myeloma DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 3-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25 19 59 , to July 31 19 59 , and that death occurred at 12:29 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 8-5-59							
ACTUAL SIGNATURE <i>J. L. Garey</i>		M.D. V.A. Hospital, Perry Point, Md. 8-5-59					
PHYSICIAN'S NAME (Type) J. L. GAREY		---Clinical Pathologist---					
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8/6/1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR AUG 7 '59	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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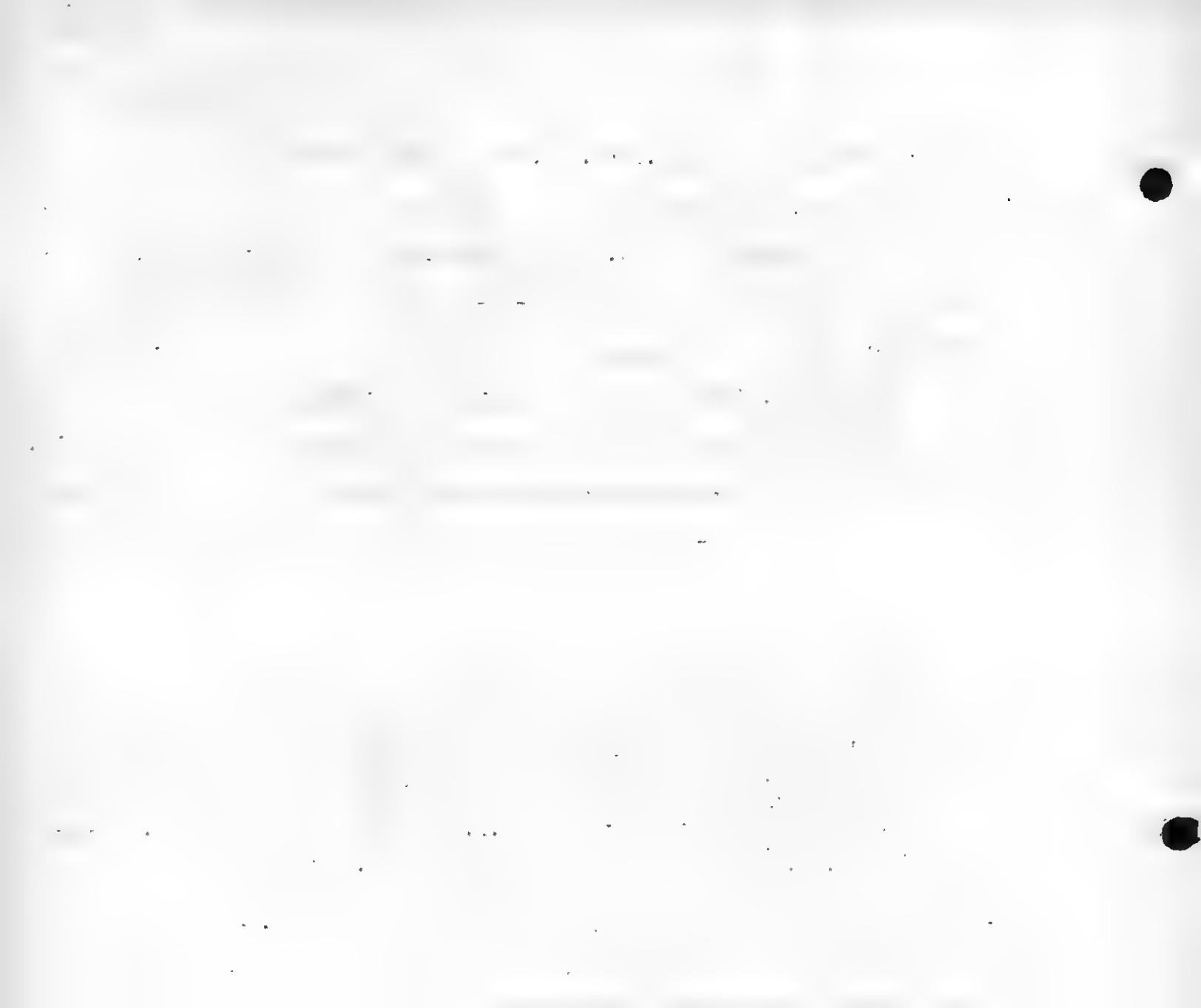
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CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia		b. COUNTY Halifax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 29yrs. 10mo. 24days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Boston			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1010-3rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ALFRED		Middle M.		Last CHILDRESS	
S. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month July Day 20 Year 19 59	
8. DATE OF BIRTH 3-15-97		9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Telegraph		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Winthrop H. Childress				14. MOTHER'S MAIDEN NAME Mattie Lee Kenney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 130.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sub-acute bacterial endocarditis, organism unknown DUE TO (c) Aortic valve, vegetations of unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, moderately severe							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 26 , 19 29 to July 20 , 19 59 and that death occurred at 12:01 am from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 7-20-59 ACTUAL SIGNATURE J. L. Garey M.D. Clinical Pathologist PHYSICIAN'S NAME (Type) J. L. GAREY							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 20		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) South Boston Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Powell Funeral Home, South Boston, Virginia				24a. REC'D BY REGISTRAR DATE JUL 29 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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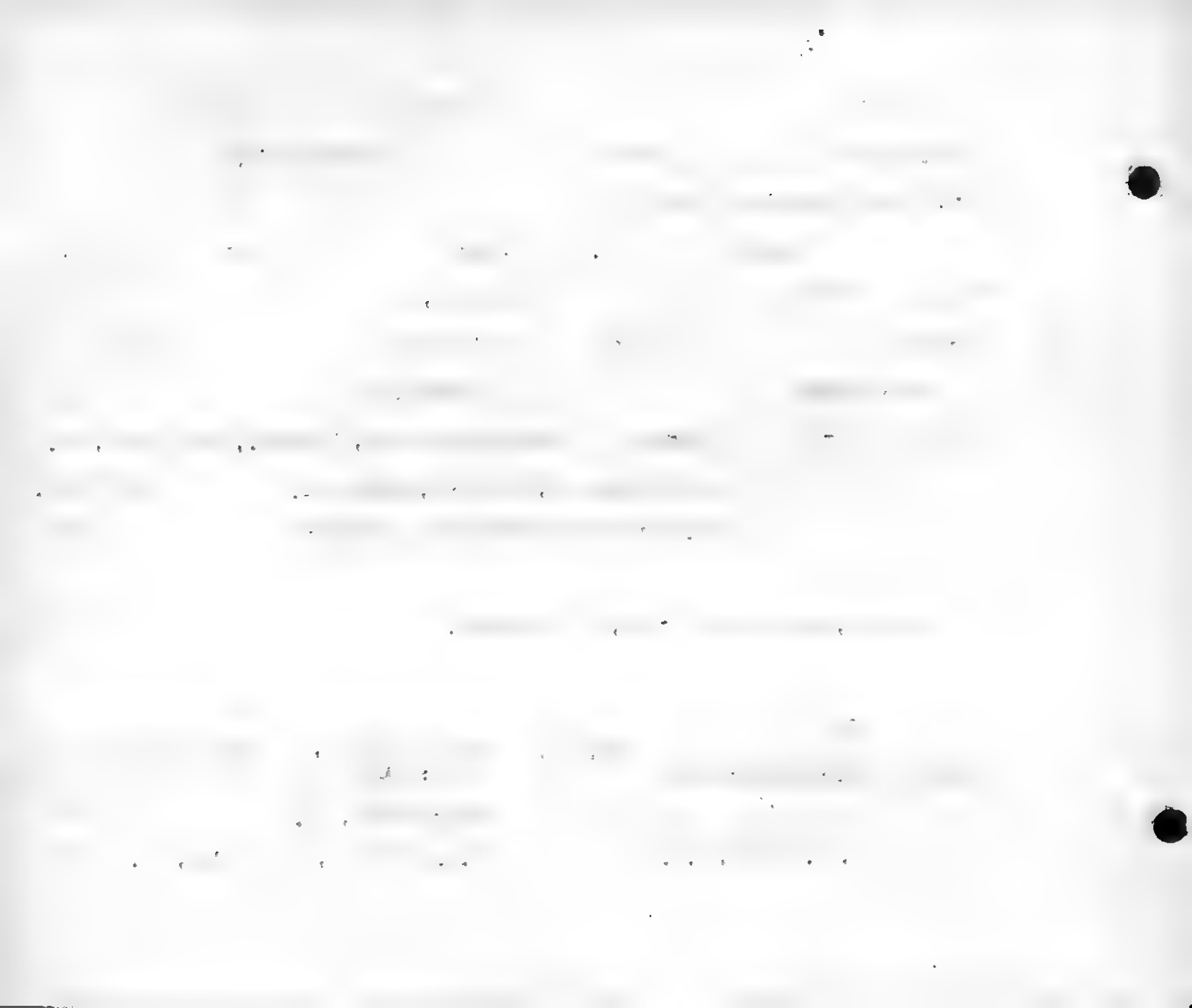
CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle J. Last CONWAY				4. DATE OF DEATH Month July Day 31 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1898		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Conway				14. MOTHER'S MAIDEN NAME Sarah Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-11		INFORMANT Hospital Records, VA Hosp., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved, 104.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rocky mountain spotted fever (Clinical) DUE TO (c) Unknown							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma, squamous cell type, of oropharynx.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 27, 1959 , to July 31, 1959 , and that death occurred at 11:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Perry Point, Md. DATE SIGNED 8-1-59							
ACTUAL SIGNATURE J. L. Garey				M.D. Perry Point, Md.			
PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.				V.A. Hospital, Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-3-1959		22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Chesapeake City, Cecil, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P Grant				ADDRESS North East, Md		24a. REC'D BY REGISTRAR DATE AUG 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7834

CERTIFICATE OF DEATH

Reg. Dist. No.

07825

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Md</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mary</u> Last <u>Crothers</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 1, 1874</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Inown-Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Crothers</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Thompson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Florence England Rising Sun, Md. R. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis,</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-renal disease</u> DUE TO _____ (c) <u>and cerebral accident</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Oct 7 - Aug 31 - 1959</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 31</u> , 19 <u>59</u> , to <u>Aug 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 2</u> , 19 <u>59</u> , and that death occurred at <u>11</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Dr. Fred H. Spivey</u> M.D. _____ PHYSICIAN'S NAME (Type) _____									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-5-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank Cem. Calvert</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas M. Miller Rising Sun Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knecht</u>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7835

CERTIFICATE OF DEATH

07826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Haven Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Cathers</u> Last <u>Ewing</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1937</u>
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u>12</u> Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mfg.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>David N. Ewing</u>	
14. MOTHER'S MAIDEN NAME <u>Mary A. Holland</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>213-05-3471</u>		17. INFORMANT Address <u>Mrs. Emma Ewing, Elkton, Md. R.D.#4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> 420.0 DUE TO <u>AKD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Embolism</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>7/21/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7:21</u> , 19 <u>59</u> , to <u>7:21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/21</u> , 19 <u>59</u> , and that death occurred at <u>10:04 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph E. Hicks</u> M.D.		ADDRESS (Street, city or town, state) <u>34 W. Main</u> DATE SIGNED <u>7-21-59</u>	
PHYSICIAN'S NAME (Type) <u>PETER STARRAKIS M.D.</u>		<u>FELIX</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sharps Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fair Hill, Cecil, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 28 59</u>	24b. REGISTRAR'S SIGNATURE <u>Cuthers & Kneale</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

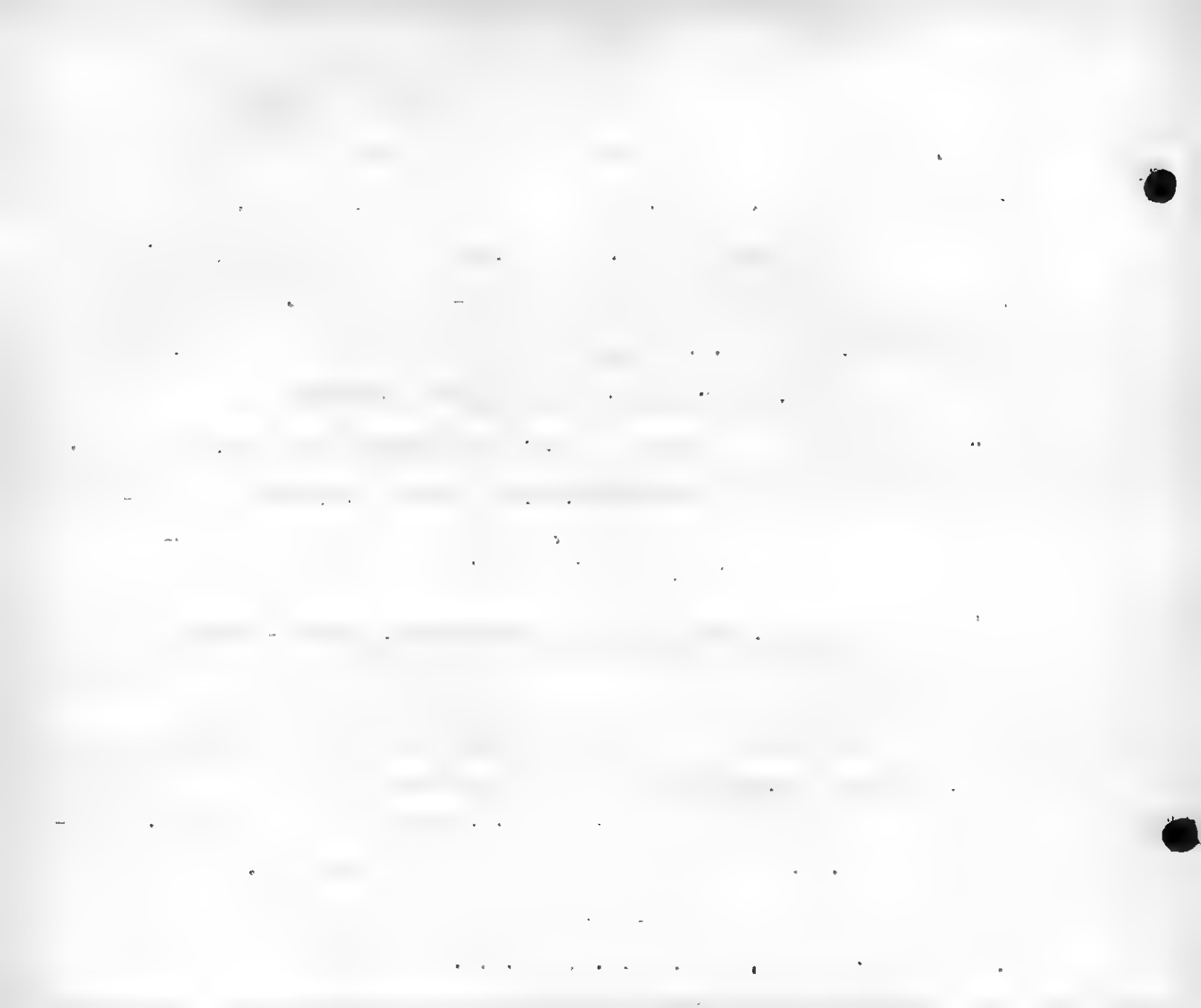
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 96

07827

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN TB 8 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		470	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2313 - 36th Street, S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLYDE Middle M. Last FRYER		4. DATE OF DEATH Month July Day 16 Year 1959	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-96 1892
9 AGE (In years last birthday) 67 6/3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Fryer - Deceased		14. MOTHER'S MAIDEN NAME Miranda Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. None	
INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic carcinoma right lung with wide-spread metastases to the left lung, bone, lymph nodes and liver (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized, severe - unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8 , 19 59 , to July 16 , 19 59 , and that death occurred at 6:45a M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 7-16-59			
ACTUAL SIGNATURE J. L. Garey M.D.		PHYSICIAN'S NAME (Type) J. L. GAREY Clinical Pathologist	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 7/19/59	
22c. NAME OF CEMETERY OR CREMATORY Circle Hill Cem.		22d. LOCATION (City, town, or county) (State) Punxsutawney Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lee, 4th St. & Mass. Ave. N.E., Wash. D.C.		24a. REC'D BY REGISTRAR JUL 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7836

CERTIFICATE OF DEATH

07828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>325 North Street</u>	
3. NAME OF DECEASED (Type or print) <u>Oliver C. Giles, Jr.</u>		4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1903</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver C. Giles, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Idella (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Mrs. Eulah Johnson Giles, Elkton, Md.</u>		Address <u>325 North St.</u>	
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO <u>260x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post-operative Thigh Amputation</u> DUE TO (c) <u>6 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/20, 1959</u> to <u>7/26, 1959</u> that I last saw the deceased alive on <u>7/26, 1959</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Fischer</u> M.D. <u>162 W. MAIN ST.</u>		DATE SIGNED <u>7/26/59</u>	
PHYSICIAN'S NAME (Type) <u>John A. Fischer</u>		<u>ELKTON, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray E. Hicks</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

7837

CERTIFICATE OF DEATH

07829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckton</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>Rt #4</u>	
3. NAME OF <u>DECEASED</u> (Type or print) First <u>Isareu</u> Middle <u>LYN</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1959</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. UNDER 1 YEAR <u>+</u> Months <u>+</u> Days <u>+</u> Hours <u>+</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Eckton Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Hall</u>		14. MOTHER'S MAIDEN NAME <u>Dolores Tamm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>James M. Hall</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute. Dystic. infection</u> DUE TO <u>Dyspnea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>June</u> Day <u>10</u> Year <u>1959</u> Hour <u>a. m.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 9</u> , 19 <u>59</u> , to <u>June 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 10</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Eckton, Md</u> DATE SIGNED <u>June 11-59</u>			
ACTUAL SIGNATURE <u>Medford H. Sprueh</u> M.D.		PHYSICIAN'S NAME (Type) <u>Medford H. Sprueh</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eckton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Eckton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter B. Bore</u> ADDRESS <u>Eckton Md</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. L. L.</u>

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7856

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07830

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)

a. STATE

Pa.

b. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Earville R.D.

c. LENGTH OF STAY IN 1b

Visiting

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Marabozz Rd. Wynnewood

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

Moreno Road.

e. IS DECEASED
ON A FARM?YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Raymond

Lawrence

Higgins

4. DATE
OF
DEATH

Month

Day

Year

7

11

19 59

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-21-1896

9. AGE (in years
last birthday)

63 yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min

11. IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Sales Mang.

10b. KIND OF BUSINESS OR INDUSTRY

Yale & Towne

11. BIRTHPLACE (State or foreign country)

St. Paul. Minn.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Higgins

14. MOTHER'S MAIDEN NAME

Dorothy Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give - 1 or dates of service)

no

no

16. SOCIAL SECURITY NO

162-01-5782

17. INFORMANT

Dorthea Higgins

Address

Mrs. Dorthea Higgins, Moreno RD. Wynnewood Pa.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute Coronary

4 + 0.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☒
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Hour o. m.
p. m.

Month, Day, Year

19

20d. INJURY OCCURRED

While
at work ☐Not while
at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒ and in my
opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL
SIGNATURE

R.C. Dodson

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

7-11-59

22a. BURIAL, CREMATION
REMOVAL (Specify)

Removal

22b. DATE THEREOF

7-12-59

22c. NAME OF CEMETERY OR CREMATORY

Annapolis National Cemetery, Annapolis Md

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

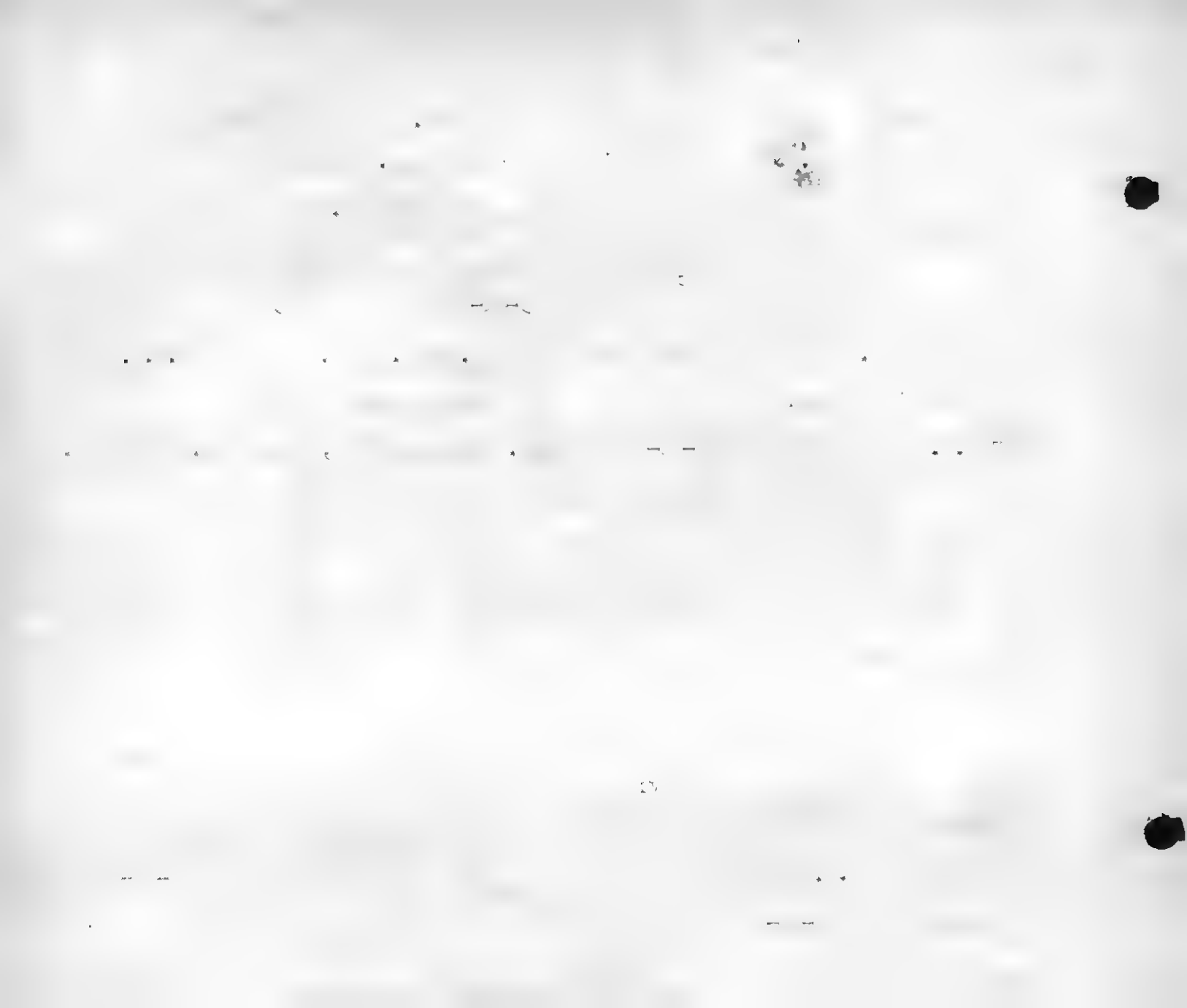
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE JUL 14 '59

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the "core, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

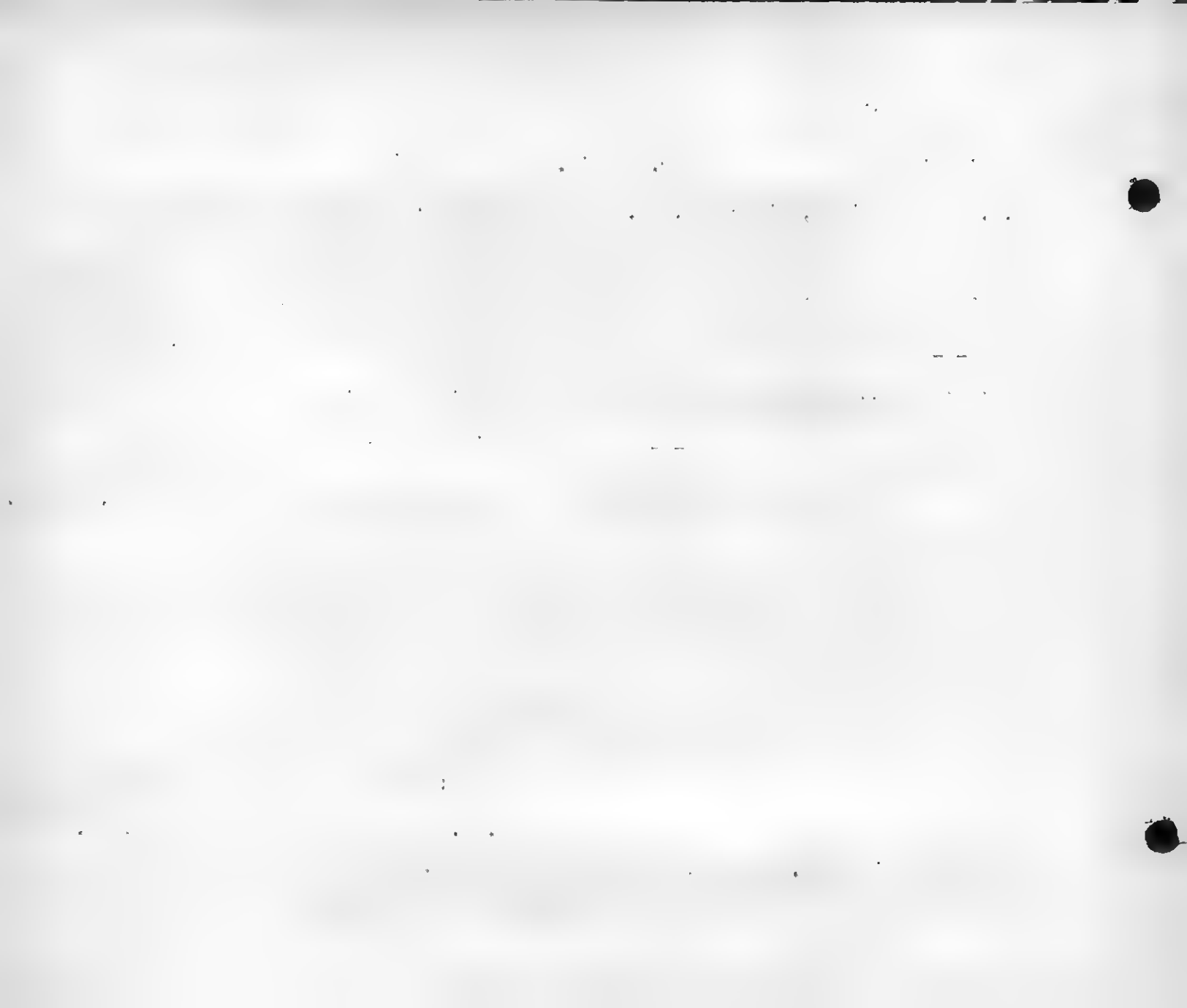
7857

CERTIFICATE OF DEATH

07831

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge		c. LENGTH OF STAY IN 1b 8 hr. 30 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bainbridge, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Manuel Middle Ricardo Last House		4. DATE OF DEATH Month July Day 4 Year 1959	
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 July 1959
9. AGE (In years last birthday) — yrs. 8 Min. 30		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William Warren House		14. MOTHER'S MAIDEN NAME Patricia Hilliard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 8 hr. 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 July , 19 59 , to 4 July , 19 59 , that I last saw the deceased alive on 4 July , 19 59 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Victor E. Cornett M.D. U. S. Naval Hospital, Bainbridge, Md. DATE SIGNED 4 July 59 PHYSICIAN'S NAME (Type) Victor E. Cornett, LT MC USNR			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		7-6-1959	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cokesbury Cemetery		Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Leola Patterson & Sons, Perryville, Md.		24a. REC'D BY REGISTRAR JUL 7 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Victor E. House	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7838

CERTIFICATE OF DEATH

Reg. Dist. No.

07832

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 21 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home				d. STREET ADDRESS 109 Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carrie P. Hudson				4. DATE OF DEATH Month Day Year July 22, 19 59					
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 21, 1882			
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME David Lusby				14. MOTHER'S MAIDEN NAME Mary Price					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO		17. INFORMANT Address Charles Q. Hudson, 109 Church St. Elkton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 14 2 2 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 3 , 19 59 , to July 22 , 19 59 , that I last saw the deceased alive on July 22 , 19 59 , and that death occurred at 9:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main St. DATE SIGNED 7/22/59 ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/59		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bethel, Cecil Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks ADDRESS Elkton, Md.				24a. REC'D BY REGISTRAR DATE JUL 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

7839

CERTIFICATE OF DEATH

Reg. Dist. No.

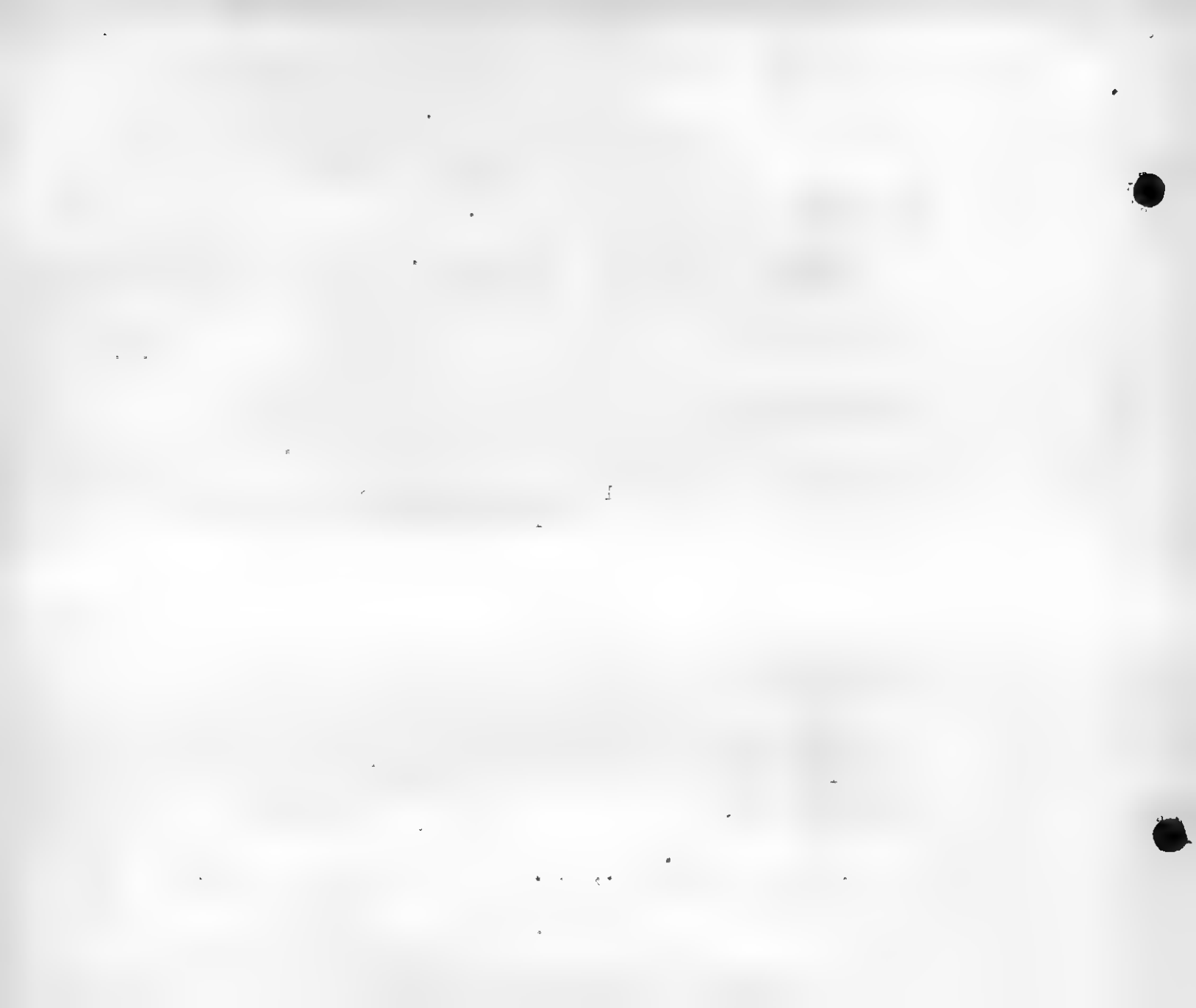
07833

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS R.D. #4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clinton Mitchell Jaquette, Sr.				4. DATE OF DEATH Month Day Year July 14 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1882		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Jaquette				14. MOTHER'S MAIDEN NAME Martha Bristow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Lone		17. INFORMANT Clinton Jaquette, Jr. Elkton, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular DUE TO renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH unknown							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 23, 1959, to July 14, 1959, that I last saw the deceased alive on July 11, 1959, and that death occurred at 2:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 233 E. Main Street July 15, 1959 ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/59		22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		22d. LOCATION (City, town, or county) (State) Bethel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter Lee Borge, Jr. ADDRESS Elkton, Md.				24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7840

CERTIFICATE OF DEATH

07834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 13 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Norman Allen		d. STREET ADDRESS 2 Norman Allen	
3. NAME OF DECEASED (Type or print) First Middle Last FRIEDA BUNTING KASISKY		4. DATE OF DEATH Month Day Year July 1, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1903
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. Maurice Bunting		14. MOTHER'S MAIDEN NAME Sara Wentz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 141-14-3322	
17. INFORMANT George J. Kasisky		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LUNG DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1, 1958, to July 1, 1959, that I last saw the deceased alive on June 30, 1959, and that death occurred at 1:35 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Davis M.D.		DATE SIGNED July 1, 1959	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/4/59	22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception	22d. LOCATION (City, town, or county) (State) Nr. Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS 100 N. 1st St. Elkton, Md.	
24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Charles S. Knaul	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 7-20-59 et

7841

CERTIFICATE OF DEATH

Reg. Dist. No.

07835

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 8 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle H. Levredge Last				4. DATE OF DEATH Month July Day 12 Year 59			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1890		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 6		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Pryor				14. MOTHER'S MAIDEN NAME Tyson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Clarence J. Levredge North East R.D.2 Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adeno. carcinoma. 151X DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) Adenocarcinoma of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 2 years 3 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 July , 19 59 , to 12 July , 19 59 , that I last saw the deceased alive on 12 July , 19 59 , and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Clarence J. Levredge M.D. North East Rd. 12 July '59 PHYSICIAN'S NAME (Type) Clarence J. Levredge							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Methodist, Harts		22d. LOCATION (City, town, or county) (State) North East R.D.2, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				24a. REC'D BY REGISTRAR DATE JUL 15 '59		24b. REGISTRAR'S SIGNATURE Clarence J. Levredge	

MEDICAL CERTIFICATION

7842

CERTIFICATE OF DEATH

Reg. Dist. No.

117836

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ekleton</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gertrude H. McAllister</u>		4. DATE OF DEATH <u>July 24 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Andrew W. Holt</u>		14. MOTHER'S MAIDEN NAME <u>Anna T. Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>Holt McAllister</u>	
17. INFORMANT <u>Ekleton</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-Vascular-Renal</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1959</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 22 1959</u> to <u>July 24 1959</u> that I last saw the deceased alive on <u>July 22 1959</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>135 W. Main, Ekleton, Md.</u> DATE SIGNED <u>Arthur S. Kline</u>			
ACTUAL SIGNATURE <u>One and the same</u> M.D.		PHYSICIAN'S NAME (Type) _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/27/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ekleton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ekleton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter duBois</u> ADDRESS <u>Ekleton</u>		24a. REC'D BY REGISTRAR <u>JUL 30 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7843
CERTIFICATE OF DEATH

Reg. Dist. No.

07837

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> RD # <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DELING HAVEN No Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BONNIE HAMILTON MCKEE</u>		4. DATE OF DEATH Month Day Year <u>JULY 21, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 2, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK HAMILTON</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE BREWER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>SARA M. COOKE</u>		Address <u>ELKTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF UTERUS</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>58</u> , to <u>July 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>59</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Chesapeake City, Md.</u> <u>7/22/59</u> ACTUAL SIGNATURE <u>Henry Davis</u> M.D. NAME (Type) <u>HENRY DAVIS M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>7/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SILVER BROOK</u>		22d. LOCATION (City, town, or county) (State) <u>WILM, DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 24 '59</u>	
ADDRESS <u>ELKTON MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

7844

CERTIFICATE OF DEATH

Reg. Dist. No.

07838

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rising Sun</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>McMullen</u> Last <u>McMullen</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5, 1879</u>		9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rising Sun Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Joseph Keyser</u>			
14. MOTHER'S MAIDEN NAME <u>Susan Connelly</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Harry C McMullen, Rising Sun, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>9 July</u> , 19 <u>59</u> , to <u>10 July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9:30 am</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Ovenshain</u> M.D.				ADDRESS (Street, city or town, state) <u>Cecilton, Md</u> DATE SIGNED <u>10 July 59</u>			
PHYSICIAN'S NAME (Type)				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>7/11/59</u>				22c. NAME OF CEMETERY <u>Friends Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Coloma</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md</u> ADDRESS			
24a. REC'D BY REGISTRAR <u>JUL 14 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7845

CERTIFICATE OF DEATH

Reg. Dist. No. 07839

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Penna.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON Cecil</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u>	
f. STREET ADDRESS <u>Greyco Apts. North St.</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sterling G. McNees</u>		4. DATE OF DEATH <u>July 15 1959</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17, 1887</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (State or foreign country) <u>Grity, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George McNees</u>		14. MOTHER'S MAIDEN NAME <u>Anna George</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>169-201-714</u>	
17. INFORMANT <u>Sterling McNees</u>		Address <u>33 Sprydel Rd Harrisburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebro-vascular Accident</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1908</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 12</u> , 19 <u>59</u> , to <u>July 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>59</u> , and that death occurred at <u>9:15</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CECILTON, Md.</u> DATE SIGNED <u>15 July 59</u>			
ACTUAL SIGNATURE <u>Wallace Openshaw</u>		M.D. <u>CECILTON, Md.</u>	
PHYSICIAN'S NAME (Type) <u>WALLACE OPENSHAW</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>7/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARRISBURG</u>	22d. LOCATION (City, town, or county) (State) <u>PENNA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		ADDRESS <u>Long St. Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 20 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Turner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07840

7845

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 4 HRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSP.		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) EVELYN FRANCIS MEREDITH		4. DATE OF DEATH JULY 28, 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1884
9. AGE (in years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 28 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES TAYLOR		14. MOTHER'S MAIDEN NAME No info.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. MARSHALL MOORE		Address CHARLESTOWN Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 yr. (c) 1 yr.		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Renal Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 July, 1959 to 28 July, 1959 , that I last saw the deceased alive on 28 July, 1959 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Blair H. Huchman M.D.		ADDRESS (Street, city or town, state) North East, Md.	
PHYSICIAN'S NAME (Type) Blair H. Huchman M.D.		DATE SIGNED 28 July '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/31/59	
22c. NAME OF CEMETERY OR CREMATORY LAWN CROFT CEMETERY		22d. LOCATION (City, town, or county) (State) CHESTER, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS ELKTON, Md.	
24a. REC'D BY REGISTRAR DATE JUL 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

MEDICAL CERTIFICATION

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7858

CERTIFICATE OF DEATH

Reg. Dist. No.

07841

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton		c. LENGTH OF STAY in 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bruce Middle Louisa Last Moore				4. DATE OF DEATH Month 7 Day 19 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29 1869		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Torbert Scarborough				14. MOTHER'S MAIDEN NAME Wilhemina Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Louise Moore Address Elkton R.D. 4 Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis of coronary arteries DUE TO (c) arteriosclerosis generalized.							INTERVAL BETWEEN ONSET AND DEATH 3 days 15 yrs 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 2 , 19 47 , to July 19 , 19 59 , that I last saw the deceased alive on July 18 , 19 59 , and that death occurred at 1:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace M. Johnson				ADDRESS (Street, city or town, state) 257 E. Main St		DATE SIGNED 7/21/59	
PHYSICIAN'S NAME (Type) Wallace M. Johnson M.D.				Newark, Delaware			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-1959		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Methodist		22d. LOCATION (City, town or county) (State) Elkton R.D. Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE JUL 23 '59	
				24b. REGISTRAR'S SIGNATURE Catharine S. Kraus			



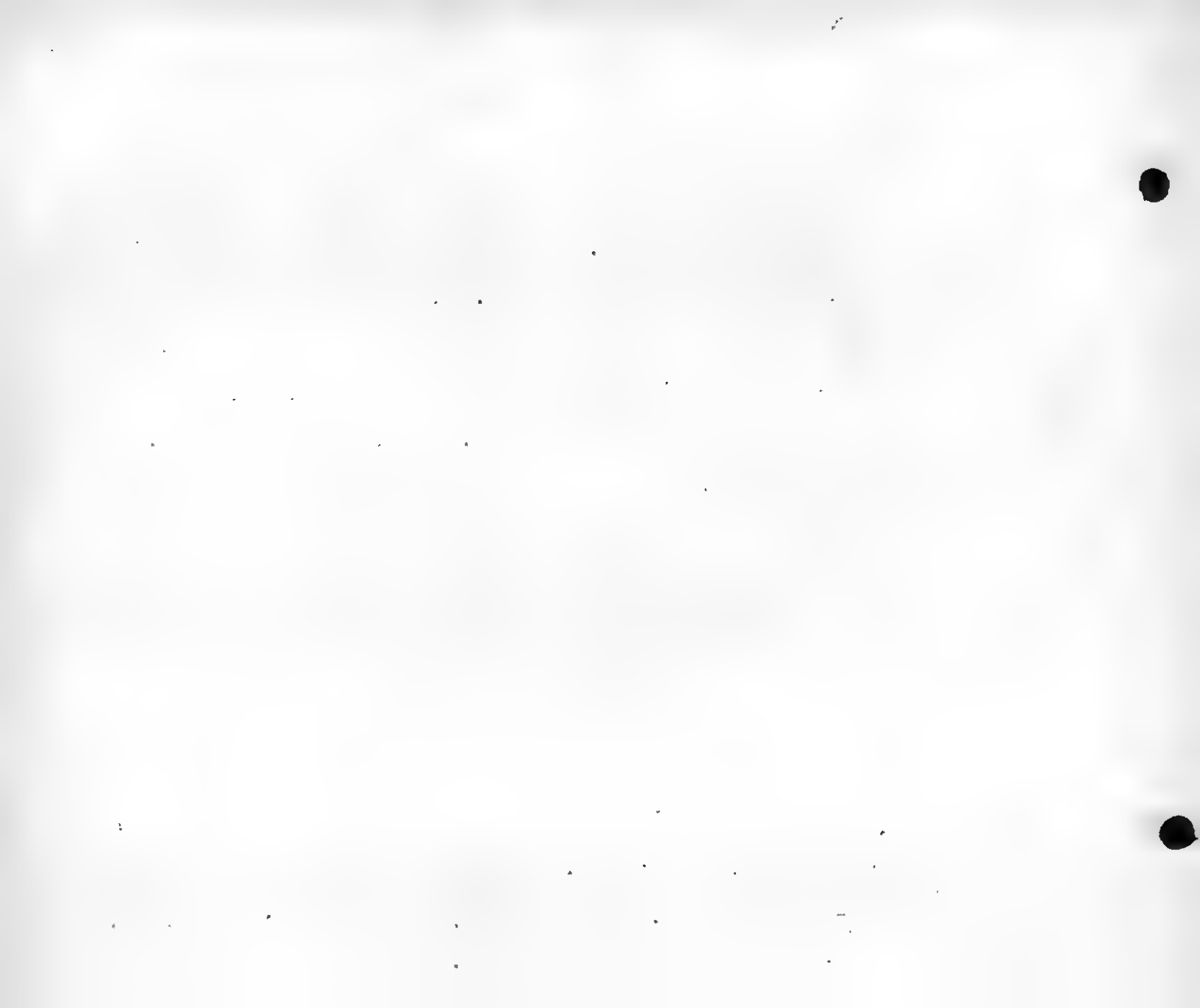
7859

CERTIFICATE OF DEATH

Reg. Dist. No.

07842

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town) Perryville		c. LENGTH OF STAY IN 1b 20 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Elm St		e. STREET ADDRESS Elm St	
3. NAME OF DECEASED (Type or print) First Mabel Middle V. Last Noel		4. DATE OF DEATH Month July Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1908
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Md	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Millard Kirby		14. MOTHER'S MAIDEN NAME Mabel Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. John F. Noel, Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 59 , to July 5 , 19 59 , that I last saw the deceased alive on June 29 , 19 59 , and that death occurred at 10:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dudley Phillips M.D.		DATE SIGNED 7/7/59	
PHYSICIAN'S NAME (Type) Dudley Phillips M.D.		ADDRESS (Street, city or town, state) Darlington Md	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Type) Burial	22b. DATE THEREOF 7-8-1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Erin Cemetery	22d. LOCATION (City, town, or county) (State) Havre De Grace, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lea Patterson Long		24a. REC'D BY REGISTRAR Perryville, Md.	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume		DATE JUL 10 '59	



TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7860 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 96 07843

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 8 mo. 14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1313 Linden Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NOEL B. SAMUELS		4. DATE OF DEATH Month Day Year July 14 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/20
9. AGE (In years last birthday) 39 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Montague Samuels	
14. MOTHER'S MAIDEN NAME Nora Walker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 218-12-4071		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral intraventricular hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Blacked out and fell.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 7-12 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. DODSON		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. DODSON		DATE SIGNED 7-14-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-15-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE JUL 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7861

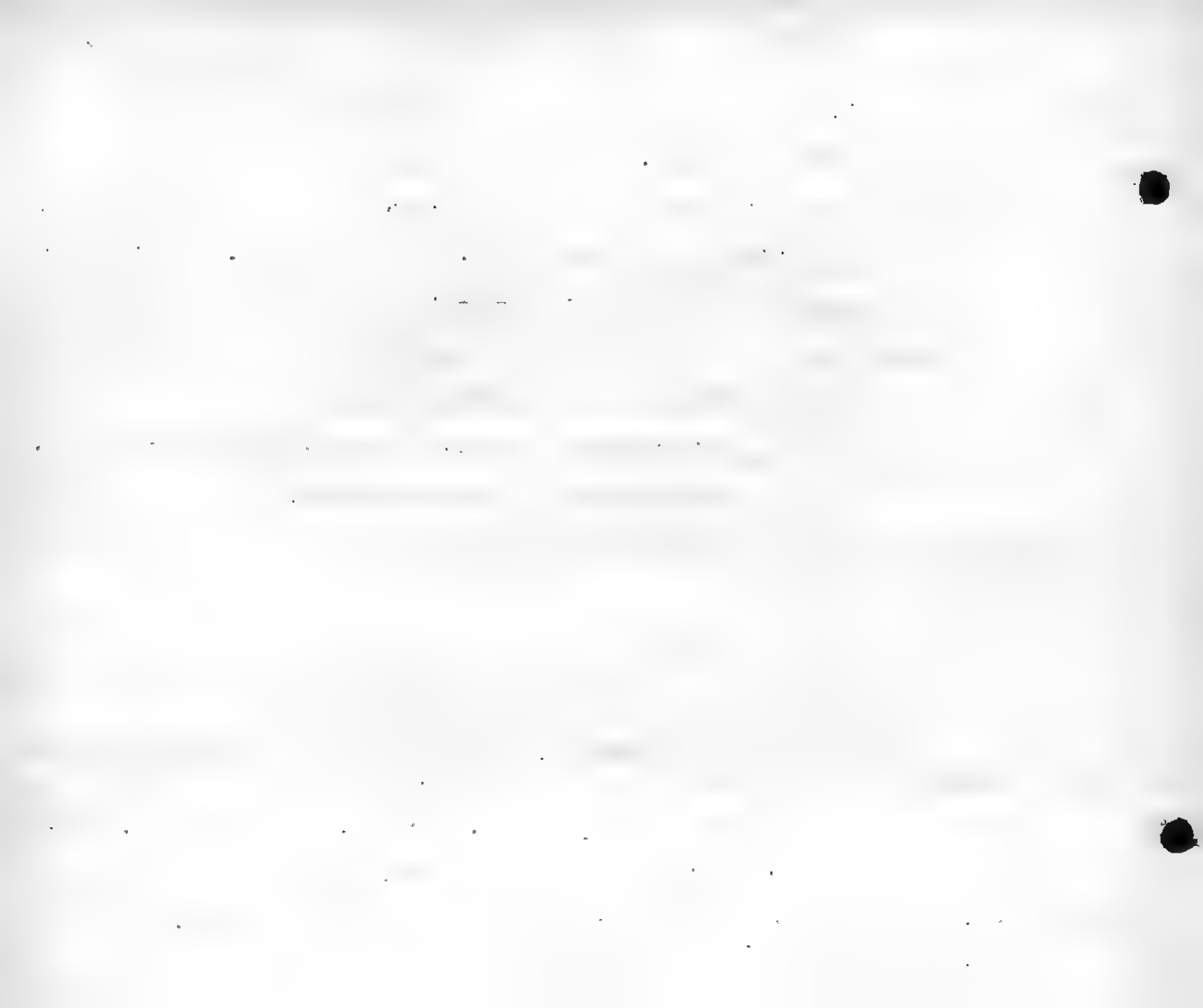
CERTIFICATE OF DEATH

Reg. Dist. No.

07844
96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN IB 8 mo. 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 120 Hemlock	
3. NAME OF DECEASED (Type or print) SCHOHE EDWARD H.		4. DATE OF DEATH Month July Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-23-92
9. AGE (In years lost birthday) 67 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Not obtainable	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Valentine Schohe		14. MOTHER'S MAIDEN NAME Minnie Brumer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Not obtainable	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 5-6 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year VA 19 Hour a. m. p. m.		20d. INJURY OCCURRED 12:00 Noon While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 27, 1958 to July 20, 1959 , that I last saw the deceased 12:00 Noon , and that death occurred at 12:00 Noon , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. L. GAREY		M.D. V.A. Hospital, Perry Point, Md. 7-22-59	
PHYSICIAN'S NAME (Type)		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) 7/23/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Uniondale		22d. LOCATION (City, town, or county) (State) Pittsburgh, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md	
24a. REC'D BY REGISTRAR JUL 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7847

CERTIFICATE OF DEATH

Reg. Dist. No.

07845

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural	
3. NAME OF DECEASED (Type or print) First Karen Middle Sinclair Last		4. DATE OF DEATH Month July Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-29-1959
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Elkton		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Meade Sinclair		14. MOTHER'S MAIDEN NAME Shirley Gatchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs Shirley Gatchell		Address North East Rd, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia (?) 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Amniotitis (?) DUE TO Prostate & rupture of membranes and I wrote by 12th hospital - August 4/58 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 761.5			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 July , 19 59 , to 30 July , 19 59 , that I last saw the deceased alive on 30 July , 19 59 , and that death occurred at 4:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 30 July 1959			
ACTUAL SIGNATURE Joseph R. Grant M.D.		PHYSICIAN'S NAME (Type) Joseph R. Grant	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-30-1959	22c. NAME OF CEMETERY OR CREMATORY North East Methodist	22d. LOCATION (City, town, or county) (State) North East, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland	
24a. REC'D BY REGISTRAR DATE JUL 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7848

CERTIFICATE OF DEATH

07846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 9 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union				d. STREET ADDRESS North East Rural			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Alta Middle Virginia Last Slayman				4. DATE OF DEATH Month July Day 8 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1908	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 4 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry Boggs				14. MOTHER'S MAIDEN NAME Leah Hubbard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 215-24-0812		17. INFORMANT Stanley Slayman North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Cor Pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Allergic Bronchial Asthma DUE TO (c) -				INTERVAL BETWEEN ONSET AND DEATH 4 months 10 yrs +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). -							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Hour - a. m. - p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) -				20g. (County) -		20h. (State) -	
21. I certify that I attended the deceased from 10 May 1959 to 8 July 1959 , that I last saw the deceased alive on 8 July 1959 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) No. 14 East, Md DATE SIGNED 8 July '59							
ACTUAL SIGNATURE Klaus H. Huchner M.D.							
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-1959		22c. NAME OF CEMETERY OR CREMATORY Baker		22d. LOCATION (City, town, or county) (State) Pound, Wise County, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant, North East, Maryland				24a. REC'D BY REGISTRAR DATE JUL 10 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kuntz	

nonsewile

Henry Boggs

no

512-24-0812

Leah Hubbard

Stanley Slayman North East, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7862 CERTIFICATE OF DEATH

07847

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1 mo. 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle (NMI) Last WALKER				4. DATE OF DEATH Month July Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1896	
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Inspector				10b. KIND OF BUSINESS OR INDUSTRY Dept. of Agriculture			
11. BIRTHPLACE (State or foreign country) England				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Peter Walker (Deceased)				14. MOTHER'S MAIDEN NAME Elizabeth Rostron (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I None			
17. INFORMANT Hospital Records, VAH, Perry Point, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lungs with metastasis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 8, 1959 to July 24, 1959 and that death occurred at 11:55am from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 7-24-59 ACTUAL SIGNATURE J. R. Garcia-Velez MD PHYSICIAN'S NAME (Type) J. R. GARCIA-VELEZ							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/27/59		22c. NAME OF CEMETERY OR CREMATORY Philo's		22d. LOCATION (City, town, or county) (State) Westernport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Boal's Funeral Home ADDRESS Boal's Funeral Home, Westernport, Maryland				24a. REC'D BY REGISTRAR JUL 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

7863 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07848

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.		c. LENGTH OF STAY IN 1b 4 mo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Meadowview	
3. NAME OF DECEASED (Type or print) First Austin Middle Jacob Last Ward 3rd		4. DATE OF DEATH Month 7 Day 13 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-1959
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 9 Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wilmington, Del.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Austin Jacob Ward, 2		14. MOTHER'S MAIDEN NAME Shirley E.N. Hallitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Ja cob Austin Ward 2nd Meadowview Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Smothered 9240 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was covered with bed clothes in sleep	
20c. TIME OF INJURY Hour 3 a. m. 713 p. m. 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Elkton, R.D. Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-13-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF JULY 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY DAMASCUS CEMETERY		22d. LOCATION (City, town, or county) (State) HANCOCK, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Donald M. Sue		ADDRESS PIPPIN FUNERAL HOME ELKTON, MD	
24a. REC'D BY REGISTRAR DATE JUL 15 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

9VVVVVVVVVVVV

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name

Residence

Age

Occupation

Sex

Color

Date of Birth

Place of Birth

Usual Residence

Married

Single

Widow

Religion

Education

W

H

Signature of Medical Examiner

Initials

Signature of Coroner

Signature of Juror

Signature of Medical Examiner

on

Signature

Signature

Signature

Signature of Medical Examiner

Signature of Coroner

Signature of Juror

Signature

Signature of Medical Examiner

Signature

Signature

Signature

Signature of Medical Examiner

Signature of Coroner

Signature of Juror

7864

CERTIFICATE OF DEATH

07849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 53 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) PAUL WASYL CZUK			First PAUL		Middle WASYL		Last CZUK	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1888		
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70		IF UNDER 24 HRS. Days 5		Hours 19		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Baking		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Peter Wasylczuk				14. MOTHER'S MAIDEN NAME Mary 666-----				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 221-03-9300		17. INFORMANT Mrs. Lena Wasylczuk, Chesapeake City, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma metastases to lung 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Prostate DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months 5 years.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Aug. 1957 to Aug 5, 1959 , that I last saw the deceased alive on July 4, 1959 , and that death occurred at 146A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chesapeake City, Md DATE SIGNED 7/1/59								
ACTUAL SIGNATURE Henry U. Davis		M.D. CHESAPEAKE CITY, MD						
PHYSICIAN'S NAME (Type) HENRY U. DAVIS MD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Roses Cem.		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS Shedden, Elkton, Md.		24a. REC'D BY REGISTRAR DATE JUL 10 1959		
				24b. REGISTRAR'S SIGNATURE Arthur L. Knecht				

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

